Garrett Regional Medical Center
MDCTO-0100
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information	
Application ID Number	MDCTO-0100
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
Organization Site Name	Garrett Regional Medical Center
DBA Name	Garrett Regional Medical Center
Website (if applicable)	gcmh.com
Ownership & Legal Structure	
Owned by Health Care Organization	No
Name of Parent Organization	N/A
Legal Structure	Non profit 501: Instrumentality of Garrett County government
Service Area	
Counties Served	Allegany County; Garrett County
Partnerships	
Formal Partnerships	Garrett County Health Department Department of Social Services Health Planning Coalition Garrett County Community Action
Informal Partnerships	N/A
Services Offered	
Tele-diagnosis	Currently in place
Tele-behavioral health	Currently in place
Tele-consultation	Currently in place
Remote Monitoring	Planned for future
Other	N/A
HIT	
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We use CRISP to view data.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.
HIT Product Name	Meditech
HIT Vendor	Meditech

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	1	N/A
Behavioral Health Counselor	N/A	N/A
Billing/Accounting Support	N/A	N/A
Care Managers - RNs	2	N/A
Care Managers - Medical Assistants	N/A	N/A
Care Managers - Other	N/A	N/A
Community Health Workers	2	N/A
Data Analysts	N/A	N/A
Health IT Support	N/A	N/A
Licensed Social Workers	1	N/A
Nutritionist	1	N/A
Pharmacists	1	N/A
Practice Transformation Consultants	N/A	N/A
Psychiatrist	N/A	N/A
Psychologist	N/A	N/A
Other	N/A	N/A

Vision

The formation of a CTO in our region will help to provide care at the most appropriate setting to lower the overall total cost of care by promoting a state of wellness and improved management of chronic disease conditions. Our CTO will consist of a multidisciplinary team made up of nurse navigators, social workers, community health workers, pharmacists, dieticians, diabetic educators and rehab therapists that provide support care and services for the residents of our region. This program will be available to all providers in our region. We currently offer this multidisciplinary team in our Well Patient Program. This program works with high and rising needs patients in our area to help them manage their disease condition in a more proactive approach. Our nurse navigators interview and assess these patients individually and develop a care plan for them based on their assessments. This information is collaborated with the primary care provider. Patients are followed in the outpatient setting via phone calls, office visits, home visits and anytime they may present back to the hospital for an ED visit or an admission. We have 24/7 access to this team. The team works with the patient to better manage their medical condition but also assist with any social resources that may be needed. This provides a holistic approach to helping patients improve their overall level of health with decreased utilization of expensive hospital resources. Garrett Regional Medical Center is also expanding our behavioral health services with a psychologist, behavioral health nurse practitioner, addictions counselor and eventually a psychiatrist. This has been identified as a high need in our area and we are excited to offer these resources to be able to better serve the residents of our region. This service will also be a part of our CTO. The Well Patient program works with all of our local physician practices. The formation of the CTO will further expand this ability. Many of our physician practices are independently owned and lack the resources for tracking and outcomes that are needed for the programs. The formation of the CTO will allow us to assist with the data tracking and outcome reporting needed to monitor the progress of the initiative. We currently utilize CRISP for reporting purposes for our high and rising needs patients. We run regular reports and gather metrics from the system. We utilize Care Alerts to provide other providers with information about the patients. The hospital uses Meditech EHR which all private practices have access to so they can also receive information on their patients. We are working with office managers in the practice to coordinate this information sharing so that providers have the latest information on their patients. The formation of a CTO in our region will help to coordinate care activities and lower the overall total cost of care by allowing services to work together to help patients manage their disease conditions. We have participated with the State of Maryland in other programs to deliver care in the most appropriate setting and feel the CTO program will expand this initiative.

Approach to Care Delivery Transformation

The CTO will utilize an interdisciplinary team approach to care delivery transformation. The nurse navigators will collaborate with the primary care providers to develop a plan of care to address all health and social needs of the patients we serve. The primary care provider will oversee the plan and receive regular updates. The plan will be agreed upon by the patient and care givers. The team will provide additional resources for the patient such as pharmacist consults for medication management, dietician for help with chronic disease conditions, social workers to help link with other community resources that may be needed such as housing or food assistance, therapists to help with strengthening or rehab needs such as cardiac and pulmonary rehabilitation, community health workers to perform home visits to assess living situations and needs. There will also be 24/7 access to the program to help decrease ED visits. ED nurse navigators will be utilized to help prevent readmissions by assessing needs and trying to link patients to services versus admission. Outcome metrics will be tracked including readmission and utilization rates, improvement in labs or other vital statistics and decrease in total cost of care. Practices will be provided outcomes for their data tracking and recording. Patient encounters will be documented in the shared EHR for all providers to be able to view as well as updates added to CRISP.